STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395561	A. BLDG: 00 B. WING:	04/28/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REFORMED PRESBYTERIAN HOME STATE LICENSE NUMBER: **183002**	**2344 PERRYSVILLE AVE** **PITTSBURGH, PA 15214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to one complaint completed on April 28, 2023, it was determined that Reformed Presbyterian was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0610 SS=D		F 0610		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0610 SS=D	Continued from page 1 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	The stated Plan of Correction does not indicate that the facility is in agreement with the stated citation. 1. Investigation to R1 was completed and on file with NHA. 2. policy and procedure to be reviewed and updated as necessary. 3. Nurses, CNAs and clinical administration team will be re-educated to the policy and procedure on Occurrences. 4. NHA will review all (100)%) occurrence reports to ensure they are thorough. Audit results will be maintained and on file with the NHA. Auditing will continue until 3 consecutive months are with 1005 compliance. 4. QAPI will receive results of occurrence report audits.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0610 SS=D	Continued from page 2 Based on review of facility policy, resident clinical records, facility provided documentation, and staff interview it was determined the facility failed to initiate a thorough investigation (omitting a statement from the resident) of an elopement for one of one residents (Resident R1). Findings include: Review of the facility policy titled " Occurrences, Investigation and Reporting" last reviewed 9/9/22, indicated the Reformed Presbyterian Home requires an occurrence report shall be completed for any situation that is out of the ordinary for a resident i.e. occurances where there is injury or the potential to result in injury. Examples of occurrences to document included elopement. Review of Resident R1's clinical record indicated the resident was admitted to the facility on 2/22/23. Diagnoses included neoplasm of the brain (brain cancer), diabetes, alcohol abuse, moderate intellectual disabilities (diminished abilities in	F 0610		

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F 0610 SS=D	Continued from page 3 intellectual and adaptive functioning), anxiety, autistic disorder (challenges with social skills, repetitive behaviors, speech and non-verbal communication), and chronic kidney disease (the kidneys inability to filter waste and excess fluid from the blood). Review of Resident R1's Minimum Data Set (MDS - a periodic federally mandated assessment that guides a resident's care) dated 2/26/23, indicated the diagnoses remained current. Review of Resident R1's Wandering Risk Assessment at admission, dated 2/22/23, recorded a score of 9, indicating the resident was at risk to wander. Review of Resident R1's current physician orders dated 4/27/23, revealed an order on 3/10/23, for a Wanderguard for resident safety related to wandering and/or exit seeking behaviors. Review of Resident R1's progress note dated 4/13/23, at 9:00 p.m documented the resident "took	F 0610		

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F 0610 SS=D	Continued from page 4 off Wanderguard got on elevator and went out front door. [Resident] made onto driveway but did not make it to sidewalk." Review of a facility provided document dated 4/14/23, did not include a statement from the resident regarding the elopement that occurred on 4/13/23. During an interview on 4/27/23, at 1:10 p.m. the Nursing Home Administrator confirmed the facility failed to initiate a thorough investigation (omitting a statement from the resident) of an elopement. 28 Pa Code 201.18 (a)(e)(1) Management 28 Pa Code: 201.29 (d) Resident rights 28 Pa Code 211.10 (d) Resident care policies	F 0610		

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F 0610 SS=D	Continued from page 5	F 0610		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 6 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1) Care Plan for R1 cannot be updated as the resident discharged prior to the survey. 2) All resident care plans of residents who are at moderate or high risk for wandering were updated. Audit on file with NHA. 3) Daily progress notes of all residents will be reviewed, and care plan updated accordingly. Audit on file with NHA. will continue until 3 months of consecutive 100% compliance. Results reported to QAPI. 4) Care Plan Policy and Procedure will be reviewed/updated as appropriate. 5) IDT and Nurses will be re-educated by NHA or DON to care plan policy and procedure. Signature sheets on file with NHA. 6) QAPI Committee to receive all	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0657 SS=D	Continued from page 7	F 0657	audit results.	

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F 0657 SS=D	Continued from page 8 Based on a review of facility policy, facility provided documentation, resident clinical record review, and staff interview, it was determined the facility failed to review and revise a resident care plan to reflect current status and needs for one of six residents (Resident R1). Findings include: Review of facility policy titled "Care Management" last revised 12/12/22, informed all aspects of the resident's medical record shall be used as part of their overall care plans. In each case, the plan of care is reviewed and revised to reflect the current needs of the resident. Review of Resident R1's clinical record indicated the resident was admitted to the facility on 2/22/23. Diagnoses included neoplasm of the brain (brain cancer), diabetes, alcohol abuse, moderate intellectual disabilities (diminished abilities in intellectual and adaptive functioning), anxiety, autistic disorder (challenges with social skills, repetitive	F 0657		

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F 0657 SS=D	Continued from page 9 behaviors, speech and non-verbal communication), and chronic kidney disease (the kidneys inability to filter waste and excess fluid from the blood). Review of Resident R1's Minimum Data Set (MDS - a periodic federally mandated assessment that guides a resident's care) dated 2/26/23, indicated the diagnoses remained current. Review of the facility's Wandering Risk Assessment scoring indicated the following: 0-8 Low risk 9-10 At risk to wander 11-above High risk to wander Review of Resident R1's Wandering Risk Assessment at admission, dated 2/22/23, recorded a score of 9, indicating the resident was at risk to wander. Review of Resident R1's current physician orders dated 4/27/23, revealed an order on 3/10/23, for a Wanderguard for resident safety related to	F 0657		

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F 0657 SS=D	Continued from page 10 wandering and/or exit seeking behaviors. Review of Resident R1's progress note dated 4/13/23, at 9:00 p.m documented the resident "took off Wanderguard got on elevator and went out front door. [Resident] made onto driveway but did not make it to sidewalk." Review of a facility provided document dated 4/14/23, indicated "bystanders saw [resident] in w/c (wheelchair) at entry of facility called facility to report resident was outside. Resident removed Wanderguard which was found in the trash. Resident exited the the third floor onto the elevator at 20:03 (8:03 p.m.) then got off at reception area (closed for the night thus noone [sic] at the desk) and sat at the door inside reception until 20:08 (8:08 p.m.) when resident opened the door to the vestibule where [resident] sat until 20:11 (8:11 p.m.) when [resident] opened the door to the outside and sat on the sit [sic] walk in w/c. Visitor approached resident at 20:29 (8:29) when then visitor called facility and notified the nursing facility that resident	F 0657		

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F 0657 SS=D	Continued from page 11 was outside. Review of Resident R1's care plan initiated 2/23/23, included the focus of impaired memory and intellectual disability with interventions of anticipate needs, provide appropriate activities and provide re-orientation aides. The care plan included the focus that the resident is at risk for elopement and related injury, with interventions to assess for elopement risk, redirect resident, encourage activities, ensure safety needs are net, functioning Wanderguard and door alarms, and to notify MD (physician) for attempts to elope and/or if current interventions are ineffective. The care plan was not reviewed and revised to reflect the actual elopement that occurred on 4/13/23, and resident specific interventions were not revised. During an interview on 4/28/23, at 11:05 a.m. the Director of Nursing confirmed the care plan and resident specific interventions for Resident R1 were not revised to reflect the actual elopement that occurred on 4/13/23.	F 0657		

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F 0657 SS=D	Continued from page 12 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.11(a) Resident care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0657		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 13 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1) All residents who have ordered wanderguards will be audited to ensure placement of the wanderguard is on the person or determined device. 2) Monthly audits of all residents with wanderguards ordered to ensure compliance with placement and orders. Audit to continue until 3 consequ months of 100$ compliance. 3) Nurses will be reeducated to wanderguard placement and Q-shift placement check. Education to be completed by NHA/DON and on file with NHA. 4) Elopement Prevention Policy and Procedure updated on 4/26/2023. All staff educated to the policy for prevention. Signature sheets on file with NHA. 5) Physician Order policy reviewed/revised. Nurses re-educated to policy and procedure.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0684 SS=D	Continued from page 14	F 0684	6) QAPI notified of citation and will receive monthly audit results.	

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F 0684 SS=D	Continued from page 15 Based on a review of facility policy, resident clinical record review, resident interview, observation, and staff interview it was determined the facility failed to follow physician orders as required to ensure a Wanderguard device was in place for one of six elopment risk residents (Resident R2) Findings include: Review of facility policy title "Physician Orders" last reviewed on 9/9/22, informed "The physician order sheet shall be utilized to ensure proper communication of care desired by the attending physician for the resident for whom he/she is responsible. The physician's initial orders shall stand as part of the baseline care plan. Review of Resident R2's clinical record indicated the resident was admitted to the facility on 8/16/21. Diagnoses included traumatic brain injury (sudden trauma to the brain), delusional disorders, paranoid personality disorder, protein calorie malnutrition an imbalance of nutrients from food and drinks needed	F 0684		

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F 0684 SS=D	Continued from page 16 to keep the body healthy and functioning), schizoaffective disorder (a mental health condition where a person experiences both psychosis and a mood disorder), depression, and anxiety. Review of the facility's Wandering Risk Assessment scoring indicated the following: 0-8 Low risk 9-10 At risk to wander 11-above High risk to wander Review of Resident R2's admission Wander Risk Assessment dated 8/16/21, score was 9, indicating the resident was at risk to wander. Review of Resident R2's Wander Risk Assessment dated 12/18/22, changed to a score was 11, indicating the resident was a high risk to wander. Review of Resident R2's current physician orders dated 4/27/23, included Wanderguard placement effective 3/3/22, Clonazepam for anxiety, Abilify for schizophrenia, and Zoloft for depression. The orders	F 0684		

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REFORMED PRESBYTERIAN HOME STATE LICENSE NUMBER: **183002**	**2344 PERRYSVILLE AVE PITTSBURGH, PA 15214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 17 remained current. Review of Resident R2's Minimum Data Set (a periodic federally mandatory assessment that guides a resident's care) dated 2/21/23, indicated the diagnoses remained current. A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R2's BIMS score dated 2/21/23, was 15, indicating the resident is cognitively intact. Review of Resident R2's care plan dated 2/20/23, addressed the resident is at risk for elopement and a	F 0684		

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F 0684 SS=D	Continued from page 18 history of elopement attempt, is unable to independently choose activities and is at risk for social isolation due to confusion/cognitive loss, is dependent on staff for meeting emotional, intellectual, physical and social needs, and suicide attempt. Review of Resident R2's progress note dated 3/2/22, documented the resident called to the police, the [resident] wanted them to take her out of here as staff took the resident's Power of Attorney number so the resident could not call. Resident R2 stated [resident] "hates this place." Review of Resident R2's provider note dated 3/2/22, documented staff reported the resident tried to leave the building. Review of Resident R2's progress note dated 3/2/22, documented at approximately 7:30 p.m. the resident called 911 and the paramedics arrived. The resident was crying that she wanted to be anywhere but here.	F 0684		

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F 0684 SS=D	Continued from page 19 During an observation on 4/26/23, at 12:55 p.m. Resident R2 did not have the Wanderguard on their person or wheelchair. Registered Nurse Supervisor Employee E5 observed the resident, and thoroughly checked the resident's wheelchair, including lifting the wheelchair cushion and looking at the underside of the wheelchair, and was unable to find the Wanderguard. The Registered Nurse Supervisor also received permission from Resident R2 to look in dresser drawers, nightstand drawer and resident's bag, and was unable to find the Wanderguard. During an interview on 4/26/23, at 1:00 p.m. Resident R2 reported not knowing where the Wanderguard was or when it was last seen. During an interview on 4/26/23 at 1:07 p.m. Registered Nurse Supervisor Employee E5 confirmed Resident R2 was without their Wanderguard and the facility failed to follow physician orders for the placement of a Wanderguard on an elopement risk resident.	F 0684		

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F 0684 SS=D	Continued from page 20 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0684		
F 0689 SS=J		F 0689		

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F 0689 SS=J	Continued from page 21 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. Elopement Prevention Policy updated. All staff re-educated to policy and procedure. Signature Sheet and Tracking on file with NHA 2. Elopement response policy and procedure updated. All staff re-educated to policy and procedure. Signature Sheet and Tracking on file with NHA 3. All staff re-educated to behaviors and risks for resident elopement. Signature sheets on file with NHA. 4. Elopement screenings updated on all residents. Audits on file with NHA. Updates to resident files as needed for wanderguard, care plan, etc. 5. Monthly audits to be completed for risk assessment, care plan and wanderguard tag of new residents and 15% of resident population. Audit results to continue until 3 consecutive months of 100% compliance.	Completion Date: **04/28/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0689 SS=J	Continued from page 22	F 0689	6. Audit results to be communicated to QAPI Committee. 7. R1 plan of care not updated as the resident was discharge from the facility prior to the survey findings.	

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F 0689 SS=J	Continued from page 23 Based on review of facility policy, facility provided documents, resident clinical record, observation, and staff interviews, it was determined the facility failed to ensure resident safety and to prevent the elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge) of a resident which resulted in an Immediate Jeopardy situation for one of 55 residents (Resident R1). Findings include: Based on a review of facility policy titled "Elopement Prevention and Response" last reviewed 9/9/22, informed the [facility] strives to promote resident safety and protect the rights and dignity of residents. The facility maintains a process to assess all residents for risk for elopement; implement prevention strategies for those identified as elopement risk, and follow a missing resident procedure. A facility approved risk assessment form will be used to evaluate the resident's physical, behavioral, psychological, and cognitive functions. If	F 0689		

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F 0689 SS=J	Continued from page 24 the assessment determines the resident scores a high risk of elopement, a physician's order will be secured for an ankle wander bracelet and the care plan updated accordingly. Staff will observe the resident and facility environment and report when a resident is at risk for elopement or has eloped. Review of Resident R1's clinical record indicated the resident was admitted to the facility on 2/22/23. Diagnoses included neoplasm of the brain (brain cancer), diabetes, alcohol abuse, moderate intellectual disabilities (diminished abilities in intellectual and adaptive functioning), anxiety, autistic disorder (challenges with social skills, repetitive behaviors, speech and non-verbal communication), and chronic kidney disease (the kidneys inability to filter waste and excess fluid from the blood). Review of Resident R1's Minimum Data Set (MDS - a periodic federally mandated assessment that guides a resident's care) dated 2/26/23, indicated the diagnoses remained current.	F 0689		

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F 0689 SS=J	Continued from page 25 A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R1's BIMS score dated 2/26/23, recorded a score of 10, indicating moderate impairment. Review of Resident R1's Nursing Admission Screening dated 2/22/23, indicated resident was confused and had a flat affect (low, or lack of emotional expression when the situation may merit a more evident reaction). Review of the facility's Wandering Risk Assessment scoring indicated the following: 0-8 Low risk	F 0689		

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F 0689 SS=J	Continued from page 26 9-10 At risk to wander 11-above High risk to wander Review of Resident R1's Wandering Risk Assessment at admission, dated 2/22/23, recorded a score of 9, indicating the resident was at risk to wander. Review of Resident R1's care plan initiated 2/23/23, included the focus of impaired memory and intellectual disability with interventions of: anticipate needs, provide appropriate activities and provide re-orientation aides. The care plan did not address the resident was at risk for wandering. Review of Resident R1's progress note dated 3/9/23, at 18:00 (6:00 p.m.), documented the "resident wandered off, wheeled self to the elevator and went to the first floor where [resident] ask receptionist to call an Uber so they can go to Blawnox (a borough in the Greater Pittsburgh area). The resident was redirected back to the third floor (skilled nursing unit in the building)."	F 0689		

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F 0689 SS=J	Continued from page 27 Review of Resident R1's progress note dated 3/9/23, at 19:07 (7:07 p.m.), documented the "resident continues to exit seek and cry throughout the unit. Wanderguard (electronic monitoring device placed on/with the resident for residents at risk for wandering/elopement) functioning properly when close or attempting to go through the doors off unit. Resident R1 continues to ask multiple staff, residents and family members to help get out of here. Very difficult to redirect." Review of Resident R1's current physician orders dated revealed an order on 3/10/23, for a Wanderguard for resident safety related to wandering and/or exit seeking behaviors. The April 2023 recapitulation reveled that order has remained unchanged since onset. Review of Resident R1's progress note dated 4/13/23, at 9:00 p.m, documented the resident "took off Wanderguard got on elevator and went out front door. Resident R1 made onto driveway	F 0689		

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F 0689 SS=J	Continued from page 28 but did not make it to sidewalk." Review of a facility provided document dated 4/14/23, indicated "bystanders saw Resident R1 in w/c (wheelchair) at entry of facility called facility to report resident was outside. Resident removed Wanderguard which was found in the trash. Resident exited the third floor onto the elevator at 20:03 (8:03 p.m.) then got off at reception area (closed for the night thus noone [sic] at the desk) and sat at the door inside reception until 20:08 (8:08 p.m.) when resident opened the door to the vestibule where [resident] sat until 20:11 (8:11 p.m.) when Resident R1 opened the door to the outside and sat on the sit [sic] walk in w/c. Visitor approached resident at 20:29 (8:29 p.m.) and the visitor called facility and notified the nursing facility that resident was outside. This area includes a small sidewalk with some parking spaces and a circular driveway to the public sidewalk, the entrance and exit to the driveway both have an incline leading down to the sidewalk with a curb to the main road running in front of the facility.	F 0689		

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F 0689 SS=J	Continued from page 29 Review of The Weather Channel's forecast for Pittsburgh, PA. on 4/13/23, revealed the high was 84 degrees and the low was 51 degrees. Review of the Nursing Home Administrator's (NHA) witness statement dated 4/19/23, documented staff returned the resident to the building at 20:31 (8:31 p.m.). The witness statement did not include a description of Resident R1's clothing at the time of the elopement. Review of Registered Nurse Employee E1's witness statement, not dated, documented the resident was seen after dinner in the hallway roaming by the common area near the nurse's station. Resident R1's alarm was going off near door earlier in the shift. During an interview on 4/26/23, at 11:40 a.m., Nursing Assistant (NA) Employee E2 reported Resident R1 was very smart and knew how to take off the Wanderguard bracelet. The employee also reported it is difficult to watch residents when	F 0689		

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F 0689 SS=J	Continued from page 30 evening care is being provided and there is not enough staff to provide evening care. The employee presented a paper of seven resident photographs with names that were the residents with Wanderguard bracelets. During an observation on 4/26/23, at 11:50 a.m., Resident R1's room was located on the section of the hall furthest from the common area/nurse's station area, opposite two closed double doors, and closest to the elevator that lead to the reception area and main entrance on the first floor. The main entrance led out to a sidewalk, parallel to the front of the building. In front of the sidewalk was a small parking area for picking up or returning residents. Parallel to the small parking lot and sidewalk was the facility driveway. At the corner of the facility driveway and side street was a public transportation stop. During an interview on 4/26/23, at 2:00 p.m., Registered Nurse (RN) Employee E4 reported Resident R1 kept removing the Wanderguard	F 0689		

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F 0689 SS=J	Continued from page 31 bracelet and that the band could be stretched or torn. The employee reported Resident R1 knew the Wanderguard set off the alarm. The resident verbalized wanting to go to Blawnox for beer and vodka. During an interview on 4/26/23, at 2:18 p.m., the NHA reported the facility had five residents that were elopement risks. During an interview on 4/27/23, at 12:15 p.m., NA Employee E2 reported Resident R1 would comment about wanting to go to a hockey game, have a beer and a shot of vodka, and would cry if unable to go out. The elopement happened when staff were doing rounds, and Resident R1 was savvy enough to leave during rounds. During an interview on 4/27/23, at 11:20 a.m., RN Employee E3 reported Resident R1 was smart, always wanted to go somewhere, knew the band triggered the alarm. Friends took Resident R1 out of the building, [resident] knew the path to the front	F 0689		

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F 0689 SS=J	Continued from page 32 door. Resident R1 left at "prime time" during P.M. care. On 4/26/23, at 3:03 p.m., the NHA was made aware Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has cause, or is likely to cause serious injury, harm, impairment, or death to a resident) was called as the facility failed to ensure resident safety for one of 55 residents and failed to prevent the elopement of Resident R1. The Immediate Jeopardy template was provided at that time and a corrective action plan was requested. On 4/26/23, at 9:02 p.m. an Immediate Action Plan was accepted with the following actions: - All residents will have Elopement Assessments Screenings completed. Elopement Risk residents will have updated physician orders, care plans, and any other necessary medical record documents. - Care plans will be updated for elopement risk residents to include interventions specific to the	F 0689		

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F 0689 SS=J	Continued from page 33 resident. - Policies will be updated: Elopement Risk Guidelines - to include assessment frequency, environmental intervention (door alarms, wanderguards), and resident interventions and redirection strategies; and Elopement and Missing Persons. - Staff education to include elopement prevention guidelines, recognizing signs and symptoms of wandering for at risk residents, elopement and missing residents response protocol, and rounding techniques to include frequency, observation of resident and behaviors, and interventions to meet resident needs before unsafe behaviors occur. - Front desk notification to include updated photograph list with names of at risk residents. Also applicable to nursing staff and facility managers. - New admission elopement risk screenings conducted and audited weekly.	F 0689		

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	395561	A. BLDG: __00_____ B. WING: _____	04/28/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REFORMED PRESBYTERIAN HOME STATE LICENSE NUMBER: **183002**	**2344 PERRYSVILLE AVE PITTSBURGH, PA 15214**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=J	Continued from page 34 - Quality Assurance and Performance Improvement (QAPI) notification and reviews. - Daily documentation for signs and symptoms of elopement risk residents for 3 months, then quarterly thereafter. During observations and interviews on 4/28/23, at 1:30 p.m., fifty-five residents had elopement screening and assessments completed, resident records were updated physician orders, care plans, and other necessary medical records documentations as appropriate, the facility had trained 93% of it's staff on the Elopement Policies, prevention guidelines, recognizing signs and symptoms of at risk residents, elopement and missing resident protocol, and rounding techniques, 14 staff interviews were conducted and confirmed receiving training on the content of the trainings, updated policies were reviewed for content, front desk notification of at risk wander residents, as well as the nursing office and staff kitchenette room was completed, two new admission elopement risk screenings were conducted, QAPI was notified on	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=J	Continued from page 35 4/26/23, at 6:45 p.m., and daily documentation for signs and symptoms of elopement risk behaviors were documented for 4/27/23, and 4/28/23. On 4/28/23, at 1:43 p.m. the Nursing Home Administrator was made aware the Immediate Jeopardy was lifted. During an interview on 4/26/23, at 12:35 p.m. the Nursing Home Administrator confirmed the facility failed to ensure resident safety and to prevent the elopement of a resident which resulted in an Immediate Jeopardy situation for one of 55 residents (Resident R1). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0689		

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P 2000	§ 211.12(f)(1) Nursing services. (f) In addition to the director of nursing services, the following daily professional staff shall be available: (1) The following minimum nursing staff ratios are required: Census / Day / Evening / Night 59 and under / 1 RN / 1 RN / 1 RN or 1 LPN 60/150 / 1 RN / 1 RN / 1 RN 151/250 / 1 RN and 1 LPN / 1 RN and 1 LPN / 1 RN and 1 LPN 251/500 / 2 RNs / 2 RNs / 2 RNs 501/1,000 / 4 RNs / 3 RNs / 3 RNs 1,001/Upward / 8 RNs / 6 RNs / 6 RNs This REGULATION is not met as evidenced by:	P 2000	1. DON will continue to staff daylight and evening shift with RNs-staff onsite and available to work for 8 hours during the shift. Shifts which start at 6:30 Am and 2:30 PM. 2. NHA Regulation reviewed with DON, HR coordinator and RN Staff. Signatures on file with NHA 3. Staff hours will be monitored weekly to ensure compliance with the stated regulation. Results of audit will be provided to QAPI Committee. Audits will continue weekly until 12 weeks consecutive weeks with 100% compliance.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/11/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 2000	Continued from page 1 Based on a three week staff schedule review, staff time sheets, and staff interview, it was determined the facility failed to provide the minimum number of registered nursing hours for the day shift on three of 21 days (4/2/23, 4/9/23, and 4/15/23) and for the afternoon shift on three of 21 days (4/7/23, 4/9/23, 4/10/23). Findings include: Review of a three week staff schedule and staff time sheets for the period of 4/2/23 through 4/22/23 revealed the facility did not have a registered nurse scheduled for 8 hours on the day shift (6:30 a.m. - 3:00 p.m.) as follows: 4/2/23 - 7.75 hours 4/9/23 - 7.75 hours 4/15/23 - 7.75 hours Review of a three week staff schedule and staff time sheets for the period of 4/2/23 through 4/22/23 revealed the facility did not have a registered nurse scheduled for 8 hours on the afternoon shift	P 2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 2000	Continued from page 2 (2:30p.m. - 11:00 p.m. as follows: 4/7/23 - 7.25 hours 4/9/23 - 7.75 hours 4/10/23 - 7.50 hours During an interview on 4/28/23, at 2:00 p.m. Human Resource Co-coordinator Employee E6 confirmed that the facility failed to provide the minimum number of registered nursing hours for the daylight shift on 4/2/23, 4/9/23 and 4/15/22 and for the afternoon shift on 4/7/23, 4/9/23 and 4/10/23.	P 2000		

Certified End Page

REFORMED PRESBYTERIAN HOME

STATE LICENSE NUMBER: 183002

SURVEY EXIT DATE: 04/28/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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